

2-45  
17-39  
X47070

FILED OCT 8 1947

Registration District No. 65

Primary Registration District No. 4115

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Triphlett  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Ida Mae Kiddle

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex 71 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Aug 12 1855  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

92 0 29 hr. min.

9. Birthplace Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Henry C. Dewar

13. Birthplace Unknown

14. Maiden name Elizabeth Ann Hester

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Bennie Kittle

(b) Address Triphlett Mo

17. (a) Burial (b) Date thereof 9/14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCullough S. L. Heipard

18. (a) Signature of funeral director Menden Mo

(b) Address.....

19. (a) 9-14-47 (b) Mildred Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Triphlett  
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10<sup>th</sup>  
year 1947 hour 10 minute 15 p. M.

21. I hereby certify that I attended the deceased from Aug 15  
1947, to Sept 10 1947  
that I last saw her alive on Sept 9 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic Myocarditis

Due to arterio Sclerosis

Due to.....

Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)..... (e) Means of injury.....

23. Signature E. W. Hartman (M. D. or other).....  
Address Salisbury Mo Date signed 9/14/47

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. '8,

District File Number

Date Filed 10-7-47

NOV 28 1947  
31 21

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, by

....., Registered Apprentice No.

working under my personal supervision.

Signed

*A. T. Leiper*

Licensed Embalmer No.

3970

P. O. Address

*Mendon Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. act  
Registrar's No. 30

Registration District No. 65 Primary Registration District No. 4115

1. PLACE OF DEATH:  
(a) County Chariton  
(b) City or town Triplitt  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State mo (b) County Chariton  
(c) City or town Triplitt  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ida Mae Kiddle  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Aug 12  
(Month) (Day) (Year)

8. AGE: Years 92 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Henry C. Heman  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Ann Neston  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Bernie Kiddle  
(b) Address Triplitt mo  
17. (a) Burial (b) Date thereof 9-14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation McClough  
18. (a) Signature of funeral director D. H. Leonard  
(b) Address Mendon mo  
19. (a) 9-14-47 (b) Mildred Boone  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute 75 P.M.  
21. I hereby certify that I attended the deceased from Aug 13 to Sept 10, 1947  
that I last saw him alive on Sept 9, 1947  
and that death occurred on the date and hour stated above.  
Immediate cause of death Chronic myocarditis

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature E. W. Hawkins (M. D. or other)  
Address Triplitt mo Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

S-30687

